Child's Health History Form

Team Lopez Chiropractic
15497 Stoneybrook West Parkway Suite 180 Winter Garden, Florida 34787 407-654-9888

Name:_____Age_____Date:_____
Address:_____City:_____ State:_____ Zip:_____
Mother's Name:_____ Father's Name:_____
Phone #:_____ SSN:_____ Birth Date:_____ __Male __Female
Reason for Consulting our Office:_____
_____

Whom may we thank for referring you?_____

Health Profile

Why is this form important?

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Addressing The Issue That Brought You To The Office

If your child has no symptoms or complaints, and is here for wellness services, please check __ ; others need to briefly describe the chief area of complaint, including the effect it has on the child.

_____

_____

If he/she is experiencing pain is it: __ Sharp __ Dull __ Comes and Goes __ Travels __ Constant

Since the problem started, is it: __ About the same __ Getting better __ Getting worse

What makes it worse?_____

It interferes with: __ School __ Sleep __ Walking __ Sitting __ Hobbies __ Other:_____

Other doctors seen for this problem:

Chiropractor:_____

Medical doctor:_____

Other:_____

List medications the child is taking or surgeries the child has had:

_____
_____
_____
_____
_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better asses the challenges to your child's health potential.

Pregnancy:

Were there any complications to the pregnancy?_____
Was Mom on any medications, prescriptions, or over-the-counter? __ Yes __ No
If yes, explain:_____
Did Mom or Dad smoke during the pregnancy? __ Yes __ No Who?_____
Was the baby ever in the Breech position? __ Yes __ No
How many ultrasounds were performed?_____

Birth and Delivery:

Where was the baby born? __ Home __ Hospital __ Birthing Center __ Other:_____
Was the delivery: __ Vaginal __ C-section Were any devices used? __ Forceps __ Vacuum
How long was the labor? _____ How long was the delivery?_____
Was oxytocin/pitocin used? __ Yes __ No Was an epidural administered? __ Yes __ No

Infancy:

Was the infant vaccinated? __ Yes __ No
Was there any prolonged use of medicines or an inhaler? __ Yes __No If yes, which:_____
Did the infant suffer any traumas such as serious falls or car accident? __ Yes __ No
Has the infant been under regular chiropractic care? __ Yes __ No

Childhood years:

Did the child have any childhood illnesses? __Yes __ No Explain:_____
Does the child play youth sports? __ Yes __ No Which Sport?_____
Has the child had any surgery? __ Yes __ No Explain:_____
Has the child fallen from a height over 3 ft? __ Yes __ No Explain:_____
Was the child involved in any car accidents? __ Yes __ No When?_____
Has there been any prolonged use of meds? __ Yes __ No Explain:_____
Has the child suffered emotional traumas? __ Yes __ No Explain:_____
Please give us any other health information you feel would be helpful:_____
_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature:_____
Date:_____